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Article

Health Insurance Politics of Japan in the 1940s and the 1950s:

The Japan Medical Association and Policy Development

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Health care reform has consistently been a heated political issue in Japanese politics. Japan began to take gradual steps to expand its health insurance system after it enacted the Health Insurance Law in 1922. It finally adopted the basis of the current legal structure of universal health insurance in 1958. The 1940s and 1950s were an especially critical period during which Japan solidified its health insurance system.

Adopting the viewpoint of historical institutionalism, this paper demonstrates what institutional and political contexts existed for stakeholders, especially the government and the Japan Medical Association (JMA), to pursue their interests. Then it will help us to rethink what kind of political role the JMA played in the policymaking process and to understand how the Japanese health insurance system has grown as it has.

Keywords: Health Insurance, Japan Medical Association, Ministry of Health and Welfare, Historical Institutionalism

Introduction

Health care reform has consistently been a heated political issue in Japanese politics. Japan began to gradually expand its health insurance system after it enacted the Health Insurance Law in 1922. It finally adopted the basis of the current legal structure of universal health insurance in 1958. The 1940s and 1950s were especially critical periods during which Japan solidified its health insurance system.¹

Policy development did not take place in a political vacuum. Reform-minded bureaucrats tried to expand the government's power while creating and rationalizing health insurance programs. On the other hand, the Japan Medical Association (JMA) made efforts to maintain doctors' autonomy from the government and secure their financial stability. This political conflict should sound familiar to many of those who study the development of health insurance policy in other countries. But the timing and structure of health insurance policy changes in Japan need to be explained not only by the relationship between the government and interest groups but also by historical, institutional and political contexts in which political actors advocated particular policy stances.

Some scholars have studied the relationship between the government and the JMA in the 1940s and 1950s. William Steslicke focused on how the JMA developed and became a powerful interest group against the government in health care reform.² Nomura Taku is another scholar who pays special attention to the JMA's political role.

¹ For the structure of the Japanese health care system, see John C. Campbell and Naoki Ikegami. *The Art of Balance in Health Policy: Maintaining Japan's Low-Cost, Egalitarian System*. New York: Cambridge University Press, 1998.

² William E. Steslicke, *Doctors in Politics: The Political Life of the Japan Medical Association* (New York: Praeger Publishers, 1973).

Unlike Steslicke, however, he indicated that despite the JMA's hostile attitude toward the government on the surface, the JMA often cooperated with the government.³ Steslicke and Nomura have provided different and rather conflicting perspectives on the political role of the JMA. This paper does not involve itself directly in this argument, but it demonstrates why the relationship between the government and the JMA appeared as it did and how it affected the path of health insurance policy by paying attention to the institutional and political development in health care during the 1940s and 1950s.

I have adopted here the viewpoint of historical institutionalism, a perspective which helps us to understand institutional and political development. Historical institutionalists suggest that institutions provide “a potentially inchoate world”⁴ with some sense of order. To understand policy development, I focus not so much on how politics leads to new policy but more on how a new policy produces a new political context. What causes drastic policy changes then, according to historical institutionalism, is exogenous shocks, such as wars. Lastly, the paper focuses on the timing and sequence of historical events by paying attention not only to whether a certain sequence of events occurred, but also when and why it occurred. Within the analytical framework of historical institutionalism, we can comprehend how institutional and political contexts in Japan shaped the interests and political strategy of the JMA and the policy trajectory to consolidate the foundation of the health insurance system Japan has now.⁵

This article first describes how health policy development after the Meiji Restoration affected health politics before World War II. The second section demonstrates how WWII, considered to be a critical exogenous shock, empowered the government to push for health care reform and achieve drastic changes in 1942. The third section shows how the wartime policy legacy, together with the result of the war and the U.S.-led occupation politics, shaped the policy alternatives in the postwar period. The last section demonstrates what institutional and political developments by the 1940s affected the movement toward universal health insurance. To highlight the unique aspects of historical contexts, this article uses the American case as a shadow comparison.

1. Health Insurance Politics before World War II

After the Tokugawa Shogunate collapsed, the Meiji government played a leading role in creating new health care institutions. A major objective of the new government was the westernization of medicine. The Tokugawa Shogunate had officially endorsed Kanpō, which was originally introduced from China, as its official medicine, but the Meiji government pushed for a legislation to officially admit and develop western-style medicine, *seiyō igaku*. By the end of the nineteenth century, the government had almost completed its mission to firmly establish western-style medicine. But it began to consider the introduction of public health insurance, which also originated in Europe.

As the number of doctors who practiced western-style medicine increased, they began to mobilize themselves in fighting against the traditional Kanpō doctors. Then, western-style doctors had to deal with the government that tried to introduce a new public health insurance program for workers. These events led them to form the JMA in 1923. The government and doctors worked together to form and develop the national medical association.⁶

(1) Transformation from *Kanpō* to Western-Style Medicine

By the time the Tokugawa Shogunate ended in 1868, Kanpō medicine had been recognized as having

³ Nomura Taku, *Nihon Ishikai* [Japan Medical Association] (Tokyo: Keiso Shobō, 1976). Major works which study the development of Japanese health care in general include Kawakami Takeshi, *Gendai Nihon Iryōshi* [History of Modern Japanese Health Care] (Tokyo: Keisō Shobō, 1965); Sugaya Akira, *Nihon Iryō Seisakushi* [History of Japanese Medical Policy] (Tokyo: Nihon Hyōronsha, 1977); Mizuno Hajime, *Daremo Kakanakatta Nihon Ishikai* [An Untold Story of the Japan Medical Association] (Tokyo: Sōshisha, 2003).

⁴ James March and Joan Olson, “The New Institutionalism: Organizational Factors in Political Life,” *American Political Science Review* 78 (September 1984): 743.

⁵ For historical institutionalism, see Paul Pierson, *Politics in Time: History, Institutions, and Social Analysis* (Princeton, N.J.: Princeton University Press, 2004).

⁶ For the history of the Japanese medicine from the ancient time to the Shōwa period, see Sakai Shizu, *Nihon no Iryōshi* [The History of Medicine in Japan] (Tokyo: Keiso Shobō, 1982).

official status. It was imported from China in the tenth century and modified into a Japanese style.⁷ Kanpō medicine stressed that people got diseases because energy (*ki*), blood (*ketsu*) and body fluid (*sui*) were ill-balanced. However, the newly created government made efforts to replace Kanpō medicine with western-style medicine.⁸

While Kanpō medicine tried to make the condition of the entire body better to alleviate the symptoms of disease, western-style medicine tended to focus on getting rid of the sources of a disease. The Meiji government stressed the effectiveness of western-style medicine partly because of leaders' experiences during the Boshin conflict with the Tokugawa Shogunate. Surgeon Major General Ōmura Masujirō noted, "(Japanese) medicine has to be westernized; Kanpō is useless in military hospitals."⁹

In 1869, the government issued its Authorization of Western-Style Medicine (*Seiyō Ijutsu Sashiyurushi*). In 1877, moreover, the Meiji government established a medical faculty, which was based on western-style medicine, at Tokyo University. This institution played a major role in leading the westernization of Japanese medicine, while other medical schools had to hire Tokyo University graduates to be officially recognized by the government.¹⁰

Although existing Kanpō doctors were allowed to continue their practice, new doctors had to be trained in the western-style medicine. The government issued the Medical Regulations Law (*Isei*) in 1874. This law stipulated that new doctors had to be graduates from an official medical school or medical vocational school and must have passed the examination that was based on western-style medical system in order to be able to start practicing. The law vigorously advanced the government's push for the westernization of Japanese medicine.¹¹

However, Kanpō doctors took the lead in establishing a national association before western-style physicians did so. To respond the government's new medical education policy, Kanpō practitioners formed Onchisha in 1879. Onchisha made strong efforts to block the government from further pursuing the westernization of medicine.¹²

As part of the response to this movement by Kanpō doctors, in 1886, western-style doctors established the Tokyo Medical Society (*Tokyo Ikai*), and similar regional medical associations began to be formed in other prefectures.¹³ The movement by western-style doctors and the government's policies to promote western-style medicine went hand in hand to diminish the power of Kanpō doctors.

However, the relationship between the government and western-style doctors was not always friendly. Western-style doctors faced a serious challenge when the pharmacist groups pushed the government to separate the sale of medicine from the medical treatments. During this time in Japan, doctors usually offered both medical treatments and medicine, and charged only for the cost of medicine. In the Tokugawa Era, people called them *kusushi*, which meant specialists in the prescription of medicine.¹⁴ To imitate the way of western-style medicine, the government was planning to have medicine sold only by pharmacists. To many western-style doctors, however, the prohibition of medicine would mean a significant loss of income; and they furiously opposed the government.¹⁵ This fight contributed to the formation of the first national association of western-style doctors, the Greater Japan Medical Association (*Dainippon Ishikai*: GJMA) in 1906.¹⁶ It was the first, if not a legal organization yet, national medical association in Japan. This new national association soon faced the government's efforts to pass a legislation to provide health insurance for workers.

⁷ There were some doctors who practiced western-style medicine during the Tokugawa Era. They typically went to Nagasaki and learned it from the Dutch doctors.

⁸ Kawakami, *Gendai Nihon Iryōshi*, 91.

⁹ Ibid., 92.

¹⁰ Sugaya, *Nihon Iryō Seisakushi*, 38.

¹¹ Ibid.; Hidehiko Kasahara, *Nihon no Iryō Gyōsei: Sono Rekishi to Kadai* [Japanese Health Care Administration] (Tokyo: Keio University Press, 1999), 15-18.

¹² Kawakami, *Gendai Nihon Iryōshi*, 155.

¹³ Ibid., 231-2. Also see Steslicke, *Doctors in Politics*, 38.

¹⁴ Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen* [Fifty-Year History of the Ministry of Welfare, Documentary Volume] (Tokyo: Chūō Hōki Shuppan, 1988), 62.

¹⁵ For the history of the JMA's resistance in this issue, see Japan Medical Association, *Nihon Ishikai Sōritsu Kinenshi: Sengo Gojūnen no Ayumi* [A Commemorative Issue of the Japan Medical Association: Fifty-Year History after the War] (Tokyo: Nihon Ishikai, 1997).

¹⁶ Kawakami, *Gendai Nihon Iryōshi*, 242.

(2) Health Insurance Law of 1922

Enactment of the Health Insurance Law (Kenkō Hoken Hō: HI) in 1922 had a big impact on health politics. While the leaders in the national medical association cooperated with the government to plan and implement the law to expand their power among doctors, the HI gave a considerable venue for the government to increase influence the medical community.

Historically, Japan lagged behind European countries in the development of health insurance. Under the leadership of Chancellor Otto von Bismarck, Germany introduced public health insurance for workers in 1883. Great Britain enacted the National Health Insurance in 1911. To learn social policy administration, in 1890 the Japanese government sent Gotō Shinpei to Europe. After coming back to Japan in 1892, Gotō started to work on legislation regarding workers' health insurance. Although this proposal did not pass in the Imperial Diet, Gotō's plan was the first serious government's push for health insurance legislation. However, part of Gotō's proposal was adopted finally when the HI, which targeted manual labors, was to be enacted in 1922.¹⁷

Two political and social movements helped this law to be passed in the Imperial Diet at that time. First, there were strong demands for male suffrage. To appeal to the new voters, the Keiseikai Party, a large minority party, began to promote a public health insurance program for manual workers. Then, the Seiyūkai Party, a conservative majority party, advanced a similar proposal. Secondly, the health insurance proposals became entangled with the rapid rise of the labor movement which itself was related to greater industrialization. The government came to see the health insurance legislation as a means to mediate labor conflicts.

As a result of these pressing circumstances, the HI was passed in the Imperial Diet by "surprising speed."¹⁸ The Law established two programs: the Association-Managed Health Insurance for large companies with more than 500 employees and the Government-Managed Health Insurance for smaller company employees. For the former program, the government gained power to regulate what health insurance plan large companies offered. For the latter, the government had much tighter control by becoming the single insurer.

The HI was decided by the government's top-down approach despite the fact that the GJMA had formal and informal negotiation channels with the government. Kitahara Ryuji points out that the GJMA was more reactive than proactive in the policymaking process.¹⁹ In addition, Kawakami Takeshi concludes that the GMJA underestimated the impact of the HI on doctors and that in effect the government unilaterally advanced the policymaking process.²⁰

However, it was not that the GJMA did not gain anything from the HI. The law gave the GJMA leaders to make the fee schedule and a means to expand their power over individual doctors. More importantly, the creation of the HI gave an opportunity for the GJMA with a particular legal status. In November 1923, the Greater Japan Medical Association was dissolved and the Japan Medical Association came into being.²¹ Kitazato Shibasaburō, who had been the president of the Greater Japan Medical Association, became the first president of the JMA.²²

The elite doctors' hope to find a venue to influence the policy-making process and individual doctors matched the government's desire to have a stronger cooperative relationship with the medical associations in order to implement health policies. However, the power distribution was tilted more toward the government. The government, for example, had the power to control the budget. The government controlled the sum total of the budget although the JMA had large discretion on how to distribute the insurance payment.²³

Medical associations, in general, are to improve the quality of medicine, to promote the professionalization of doctors, and to secure their financial success. But in comparison with their American counterparts, such

¹⁷ Kawakami, *Gendai Nihon Iryōshi*, 226, 348-9. See also Gotō Shinpei, "Shitsubyō no Hokenhō [Sickness Insurance]," in Shakaihoshō Kenkyūsho ed., *Nihon Shakaihoshō Zenshi Shiryō: Shakaihoken* [Pre-history of Japanese Social Security: Social Insurance] (Tokyo: Shiseidō, 1981), 6-12. In 1892, Gotō became the Chief of the Hygiene Bureau, recommended by Nagayo Sensai who was the first Chief.

¹⁸ Kōseishō Imukyoku, *Isei Hyakunen* [One-Hundred-Year History of Medicine] (Tokyo: Gyōsei, 1976), 222.

¹⁹ Kitahara Ryuji, *Kenkōhoken to Ishikai: Shakaihoken Sōshiki niokeru Ishi to Iryō* [The Health Insurance System and the Doctors' Association in Japan: Doctors and Medicine at the Beginning of the Social Health Insurance] (Tokyo: Tōshindō, 1999), 70.

²⁰ Kawakami, *Gendai Nihon Iryōshi*, 358.

²¹ The Health Insurance Law was originally planned to be implemented from April 1924, but the Great Kanto Earthquake occurred in 1923 and the implementation was delayed until January 1927.

²² Kawakami, *Gendai Nihon Iryōshi*, 242. Steslicke, *Doctors in Politics*, 43-44.

²³ Nomura, *Nihon Ishikai*, 29-31.

associations in Japan played fewer roles in medical education and licensing because the central government had the authority to intervene in the health care system.

In the United States, because the federal government had limited power in domestic affairs and because state governments had limited administrative capacity, the American Medical Association (AMA) and regional medical associations got involved more actively in developing the medical education and licensing system during the same period.²⁴ When the JMA was created, on the other hand, it essentially became an organization for the government to implement its first public health insurance policy. The JMA elite wished to be independent of the government, but it was in fact partly absorbed in the government's health care system nearly from its inception. This status became more obvious in the 1930s as Japan expanded overseas military activities.

2. WWII and Health Insurance Politics

When the government began to mobilize the entire nation for total war in the 1930s, the government gained more power to push for radical health care reform. On the other hand, the JMA was effectively turned into a state organization that was subordinate to the government. The JMA then lost its autonomy when the government redefined medicine, including health insurance, as a part of its war mobilization policy.

(1) Expansion of Health Insurance

International events, including the Manchurian Incident in September 1931 and Japan's withdrawal from the League of Nations in March 1933, isolated the country from much of the international community. The Japanese government now began to prepare for a possible future full-scale war with China. The government saw health policy as a means to boost the health of soldiers, workers and the rest of the population in winning such a war. After the Marco Polo Incident in July 1937 took place and Japan started a war with China, the government made efforts to expand its power in health care and expanded public health insurance. The creation of the National Health Insurance Law (Kokumin Kenkō Hoken Hō) in 1938, the White-Collar Workers Health Insurance Law (Shokuin Kenkō Hoken Hō), and the Seamen's Insurance Law (Sen-in Hoken Hō) in 1939 could not have been achieved, at least at the timing, without the escalation of Japan's war with China.

The military thus played a great role in supporting the government's intervention in health care. In the mid-1930s, rural Japan was experiencing long-term economic depression. In these circumstances, the Army began to ask for relief measures, including health care improvements for rural areas not only because it sought to expand its political influence in the government but also because it conscripted young men in rural areas; 85 percent of servicemen came from rural areas.²⁵ Koizumi Chikahiko, a career army officer and director of the Army's Medical Care Bureau, was the leading figure in the Army to push for health care measures for rural areas.²⁶

The breakout of the Marco Polo Incident in July 1937, which started the Second Sino-Japanese War, gave the Army even more incentive to achieve these goals. Prime Minister Konoe Fumimaro and "progressive government bureaucrats," *kakushin kanryō*, expressed their support for the Army's aspiration. Accordingly in April 1938, the National Health Insurance Law was passed in the Imperial Diet. It was initially a voluntary program, targeting farmers and other self-employed persons. The JMA tried to kill the bill but could not because of pressures generated by the war.²⁷

The war with China was first seen as a short-term conflict. But Japan's forces soon got bogged down, just as the government was trying to enact two other health insurance measures in 1939: the White-Collar Workers Health Insurance Law and the Seamen's Insurance Law. In particular, the White-Collar Workers Health Insurance proposal came with two new institutional mechanisms. First, unlike the preceding HI, it required a copayment of twenty percent of the cost of care. Second, which was more damaging to the JMA's political power, it set up a fee-

²⁴ Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 90-91; Martin Kaufman, *American Medical Education. The Formative Years, 1765-1910* (Westport, Connecticut: Greenwood Press, 1941), 127-30.

²⁵ "Donzoko no Nōmin Kyūsai: Kyūbō ni Mikanete Rikugun mo Tsuini Tatsu [Relieving Farmers: The War Ministry Finally Got Involved in the Relief Project]," *Yomiuri Shimbun*, June 7, 1932.

²⁶ Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi*, 379.

²⁷ Ibid.; Kawakami, *Gendai Nihon Iryōshi*, 428.

for-service payment system based on an official point system (*kinrō teigaku shiki*). This was quite different from the HI in which the payment to doctors was based on how many enrollees the particular doctor had (*jintō ukeoi shiki*). This change in the fee schedule, according to Kawakami Takeshi, allowed the government to maintain the upper hand in setting the fees and thus reducing the power of the JMA.²⁸

When Konoe presented the geopolitical scheme of the Greater East Asia Co-Prosperity in July 1940, the government began to seek a more drastic reform in health care in connection with the war mobilization. To make more drastic reforms, Koizumi was appointed as the Minister of Health and Welfare in July 1941. He introduced the slogan “healthy soldiers, healthy people,” *kenmin kenpei*. To him, what was making Japanese medicine inefficient was the existing health care system which lacked strong official leadership and relied too heavily on private doctors.²⁹

Koizumi pushed for a radical expansion of public health insurance. In February 1942, the Health Insurance Law was amended to include workers’ dependents. Meanwhile, the government amended the National Health Insurance Law to make the establishment of the National Health Insurance associations mandatory.³⁰ These reforms were led by Koizumi who proposed that “all people should have health insurance (*kokumin kaihoken*),” a phrase adapted from the wartime slogan “all people are soldiers (*kokumin kaihei*).”³¹ In this way, the health insurance coverage increased to more than 70 percent of the population by the end of the war.

The government took this wartime opportunity to expand its power in setting the national health insurance fees. In February 1943, the government standardized the fee calculation for the HI, the Seamen’s Insurance and the NHI. The Ministry of Health and Welfare (MHW) became responsible for deciding the common medical fees of these programs with advice from the JMA, the Japan Dental Association and the Japan Pharmaceutical Association. In June 1944, the Committee on Health Insurance Medical Fees (Shakai Hoken Shinryōhōshū Santei Iinkai), located in the MHW, began to institutionalize the fee-setting process. The Committee was composed of 11 members from the JMA, the JDA and the JPA, 11 from public hospitals, the national health insurance associations and others, and 11 representatives from the central government.³² Even though the committee included representatives of medical interests, the balanced member allocation was nominal, as Sugaya Akira points out, because the government took control in this committee.³³

(2) Nationalized JMA

In addition to the expansion of public health insurance, Health and Welfare Minister Koizumi pushed for a drastic proposal to change medical providers that relied largely on the private sector. He urged the JMA to reform itself and meet the government’s demand saying, “Of course, the reform is urgent. We are in a new era. We have to change the old system. Reform! Right now! The JMA must immediately have its own reform in adjusting to the new era. Otherwise, the government will impose reform on the JMA.”³⁴ In the intensifying nationalistic mood, again, the JMA could not resist.

Then, major reforms came to the JMA. In February 1942, first, the National Medical Treatment Law (Kokumin Iryō Ho) was passed to restrict the construction of private hospitals, increase the number of public hospitals, and educate and reallocate medical professionals. As part of this law, in April 1942, the Japan Medical Corporation (Kokumin Iryō Dan) was established to lead the policy implementation. Inada Ryōkichi, professor at Tokyo Imperial University, was appointed by the government as its president.³⁵

To advance the reform of medical providers, in August 1942, the government issued an ordinance stipulating that the JMA was to be reorganized as a new state entity, which all doctors would be compelled to join and cooperate with the government’s war activities. The MHW nominated the president of the reorganized JMA with the concurrence of the Prime Minister. The Japan Medical Corporation president Inada was appointed as the

²⁸ Kawakami, *Gendai Nihon Iryōshi*, 440-41; Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen*, 532, 543.

²⁹ Kawakami, *Gendai Nihon Iryōshi*, 438-9.

³⁰ Ibid., 440-41; Sugaya, *Nihon Iryō Seisakushi*, 200-1.

³¹ Gregory J. Kasza, “War and Welfare Policy in Japan,” *The Journal of Asian Studies* 61 No. 2 (2002), 424.

³² Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen*, 552-3.

³³ Sugaya, *Nihon Iryō Seisakushi*, 200.

³⁴ As quoted in Nomura, *Nihon Ishikai*, 45-6.

³⁵ Kōseishō Gojūnenshi Henshū Iinkai, *Kōseishō Gojūnenshi: Kijutsu Hen*, 423; Takei, *Kōseishō Shōshi*, 91-7.

new JMA president. At that time, the JMA lost its autonomy. As Miwa Kazuo puts it, the JMA's "liberal tradition, inspired by Fukuzawa Yukichi, Kitazato Shibasaburō and Kitajima Taichi, died out."³⁶ The JMA was turned into the government's tool to fight the war.

In these ways, the war led Japan to expand its power in health care. But the Japanese wartime policy and political development were significantly different from the American case. On one hand, Japan adopted a near universal health insurance system and the JMA almost completely lost its voice to the government. On the other hand, the United States expanded the private health insurance and the AMA maintained more autonomy and successfully blocked reformers' proposals to introduce a universal health insurance system. This contrast resulted not only because the JMA was already enmeshed in the implementation of the HI, but also because the Japanese government was able to gain more power by experiencing longer and more devastating conflict than the war which the United States experienced.³⁷

The timing of events also has to be taken into consideration. World War II came "too soon" for the JMA whereas the AMA had functioned as a powerful professional interest group since its formation in 1847. The JMA had far less time (about twenty years after the creation of Greater Japan Medical Association) to establish as a full-fledged interest group. More immature JMA could not resist the government's initiatives. The war radically changed the institutional and political contexts, and they constrained what the government and the JMA could do after the war.

3. Postwar Health Insurance Politics and the JMA

Japan lost the war and the U.S.-led occupation began in September 1945. Although the occupation authority introduced drastic policies to demilitarize and democratize Japan, it did not change much of the basic health insurance system. That is because the occupation politics maintained the strong power of the government and made the JMA powerless, which helped Japan to solidify the existing system.

While the occupation authority conducted a purge of public officials, it had little impact in the MHW. The occupation authority also had cooperative relations with Japanese bureaucrats in planning or implementing increment health care reforms. On the other hand, as part of democratization policy, the occupation authority ordered that the JMA be reorganized and become a voluntary organization. But this had little effect on the new JMA's power. It was only after the occupation ended and the government had nearly completed preparations for the establishment of universal health insurance that the JMA tried to be a full-fledged interest group in earnest.

(1) GHQ's Health Insurance Policy

After the war was over, movements to expand public health insurance intensified in many other war participants. In Great Britain, the National Health Service was created in 1948 based on the Beveridge Plan that was released in 1944. In the United States, immediately after the war, Harry Truman proposed that the country introduce a universal health insurance system and commenced a political battle against opposing forces such as the AMA.³⁸

A similar movement for public health insurance also occurred in Japan. During the war, reform-minded officers had sought to expand the public health insurance for war mobilization by cooperating with the Army. After the war, they worked with GHQ to expand the public health insurance for democratizing and stabilizing the Japanese economy and society. Serious study about health insurance reform began when the Social Insurance Investigation Committee (Shakai Hoken Seido Chōsakai) was established in March 1946. It later submitted the Social Security System Outline, which advocated "not patchwork but a progressive, comprehensive social security system."³⁹ The

³⁶ Miwa Kazuo, *Mōi Takemi Tarō* [Fighting Doctor, Takemi Tarō] (Tokyo: Tokuma Shoten, 1995), 171.

³⁷ For the detailed description about the development of the health insurance policy during the war, see Takakazu Yamagishi, *War and Health Insurance Policy in Japan and the United States: World War II to Postwar Reconstruction* (Baltimore: Johns Hopkins University Press, 2011); Gregory Kasza, "War and Welfare Policy in Japan." *The Journal of Asian Studies* 61 No. 2 (2002): 417-35; Shō Kashin. *Nihongata Fukushi Kokka no Keisei to Jūgonen Sensō* [The Fifteen-year War and the Formation of Japanese Welfare State] (Kyoto: Minerva Shobō), 1998.

³⁸ Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare* (Columbia: University of Missouri Press, 1979).

³⁹ Shakai Hoshō Kenkyūjo, ed., *Nihon Shakaihoshō Shiryō I* [Material for Japanese social security, part 1] (Tokyo: Shiseido, 1988), 163-67.

Beveridge Report earlier released in Britain also encouraged the Japanese bureaucrats and scholars in the committee to make this proposal, which some called the “Japanese Beveridge Plan.”⁴⁰

GHQ also favored reorganization of health insurance programs. The Public Health and Welfare Section (PHW) was created and social security reform, including health care reform, fell to Crawford Sams, the head of the PHW. In April 1946, the Labor Advisory Committee, which was established in GHQ, released an interim report to make recommendations to the PHW. It concluded that “a comprehensive reform of social insurance can and should be undertaken.”⁴¹ The Committee was also inspired by the new policy development in Britain.⁴² In June 1947, GHQ made a more concrete recommendation that the National Health Insurance be strengthened by increasing national subsidy and proposed that several health insurance programs be integrated into a single program.⁴³

To advance discussion of social security reform, the Social Security Mission was dispatched from the United States. The Mission reflected the occupation government’s goal of the comprehensive reform of Japanese health care. The mission was composed of officials of the Social Security Administration, including William Wandel, who led the mission. The mission issued a report to make the health insurance system financially stronger and achieve universal coverage in the future.⁴⁴

Although these moves did not achieve a British-style health service, most Japanese did not question a strong role for the government to strengthen the public health insurance system.⁴⁵ The bureaucrats institutionalized and enhanced its control in the health care finance which they had gained during the war. In 1950, the government created the Central Social Insurance Medical Council (Chūō Shakai Hoken Iryō Kyōgikai) that incorporated insurance administrators, representatives of the public interest, and health care providers into a centralized fee-setting arrangement for all national health insurance programs.⁴⁶ Although the fee-setting organization included representatives of doctors, the government retained enough power to exert a large influence on the health insurance finance.⁴⁷ Thanks to the fee-setting mechanism, the government succeeded in controlling health care costs after the war even while inflation was underway. In contrast, the JMA members suffered financially from lower insurance fees, but the JMA did not have the political power to resist the government.

(2) Reorganized JMA

In due course, the occupation authority decided to break up the nationalized JMA as it did to *zaibatsu* (big business conglomerates) as part of the overall strategy of demilitarization and democratization of Japan. Accordingly, the JMA was dissolved in October 1947. The newly created JMA was to “be established based on the free will and self-awareness of doctors” and “dedicated to promote medical ethics, to improve and propagate medical knowledge and techniques, and to advance public health as a means of improving the social welfare.”⁴⁸

While the GHQ successfully reorganized the JMA, it did not empower the new JMA in the policy-making process. The GHQ did not see the JMA so much as a new democratic group to advance its initiatives but, in many cases, as an obstacle to the introduction of American-style reforms. When it was to be reorganized, the JMA proposed a list of new executive members to the GHQ. But the GHQ refused it because it had people who served as high-ranking government officers during the war. The GHQ aimed to sweep away wartime leaders of the JMA.⁴⁹

⁴⁰ Takashi Saguchi, “Bebarijji hōkokusho to wagakuni shakai hoshō keikaku: Nihon shakai hoken shi no issetsu [Plan on Japanese Social Security and Beveridge Report: A History of Japanese Social Insurance],” *Waseda shōgaku* 143 (January 1960): 71.

⁴¹ SCAP PHW, “Advisory Commission on Labor First Interim Report,” 2, April 5, 1946, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907-1966, Box 9382, File 8, NACP.

⁴² SCAP PHW, “Report on the Japanese Social Insurance Programs by the Labor Advisory Committee,” 5, May (no date) 1946, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907-1966, Box Com 2-Japan, NACP, 5.

⁴³ Shakai Hoshō Kenkyūjo, ed., *Nihon Shakaihoshō Shiryō I*, 10.

⁴⁴ Sugiyama Akiko, *Senryōki no Iryōkaikaku* [Medical Reform in the American Occupation] (Tokyo: Keisō Shobō, 1995), 101-4.

⁴⁵ For the background of health insurance policy reform in Japan during the American occupation, see Adam D. Sheingate and Takakazu Yamagishi, “Occupation Politics: American Interests and the Struggle over Health Insurance in Postwar Japan,” *Social Science History* 30 No.1 (Spring 2006): 137-64.

⁴⁶ Nomura, *Nihon Ishikai*, 67-8; Yoshihara Kenji and Wada Masaru, *Nihon Iryō Hoken Seidoshi* [History of Japanese Health Insurance] (Tokyo: Tōyō Keizai Shinpōsha, 1999), *Nihon Iryō Hoken Seidoshi*, 125.

⁴⁷ Nomura, *Nihon Ishikai*, 56.

⁴⁸ Nihon Ishikai Sōritsu Gojūshunnen Kinen Jigyō Suishin Inkai, *Nihon Ishikai Sōritsu Kinenshi: Sengo Gojūnen no Ayumi* [Anniversary of foundation of the Japan Medical Association: Fifty-year progress after World War II] (Tokyo: Nihon Ishikai, 1997), 10. Meanwhile, the 日本医療団 was also dissolved.

⁴⁹ Nihon Ishikai Sōritsu Gojūshunnen Kinen Jigyō Suishin Inkai, *Nihon Ishikai Sōritsu Kinenshi*, 9.

There were other conflicts. For example, Crawford Sams, head of the Public Health and Welfare Section, took the leadership to get rid of German-style academic factions and introduced an intern system in Japan.⁵⁰ Sams also tried to clarify the division of labor between doctors and pharmacists; he believed that all doctors cared only about selling drugs and did not pay attention to the advancement of medical technology. In resisting the PHW in 1950, the only thing Tamiya Takeo, the JMA's president, could do was just to resign.⁵¹ The GHQ insisted that the JMA be a more democratic organization, but on many occasions, it did not allow the new JMA to make its own decisions in many occasions.⁵²

One should note that the JMA was in a defensive position not only because of wartime cooperation with the government, but also because the new Constitution empowered the government to intervene in health care. Article 25 of the new Constitution, which was written under the strong leadership of the occupation government, stipulated, "All people have the right to maintain the minimum standards of wholesome and cultured living. In all spheres of life, the state shall use its endeavors for the promotion and extension of social welfare, and of public health."⁵³ This provision helped to create an environment in which the government and the GHQ worked together to oppose the JMA representation of private interests.

Contrasting the American case helps us further to highlight the situation that the JMA faced in the postwar period. With the war victory, the AMA was not blamed for its cooperation with the government's war activities; rather, it could claim that its contribution to winning the war helped to protect Americanism, particularly the idea of freedom. In addition, the AMA did not have to reorganize itself and it could retain its capacity to defeat Truman's universal health insurance plan. Because of Japan's war, on the other hand, the JMA was forced to reorganize and had only limited opportunity to influence on the policy-making process. While the JMA was put into a defensive position, the government continued to consolidate the health insurance system that was developed in accordance with wartime policies.

4. The Path toward Universal Health Insurance

The first half of the 1950s was the period when the Japanese government began to push hard for universal health care. As described, bureaucrats had gained considerable power in health care by this time while the JMA was still struggling to recover influence and authority. Takemi Taro was elected as the JMA president in 1957 to take strong leadership and began to press the JMA's voice in policy-making process, but he was too late for making drastic change to existing institutional settings.

(1) The Offensive Government

In December 1948, the Japanese government created the Advisory Council on Social Security (Shakai Hoshō Seido Shingikai) as a cabinet-level organization. With 40 members, it played role in studying, planning, and recommending policies. A report the Council submitted to Prime Minister Yoshida Shigeru in October proposed to reform workplace-based programs and require the uninsured people to join the National Health Insurance, which was a residence-based program.⁵⁴ The report to Yoshida set forth an outline of Japan's future health insurance system.

In 1950, the government took a step to reconfirm its power in health care finance by replacing the Committee on Health Insurance Medical Fees, created in 1944, with the Central Social Insurance Medical Care Council (Chūō Shakai Hoken Iryō Kyōgikai, called Chūikyō). The new Council met every two years to determine the national fee schedule which applied for all national health insurance programs with the advice of medical

⁵⁰ Sugaya, *Nihon Iryō Seisakushi*, 494-97.

⁵¹ Takemi Taro, *Jitsuroku Nihon Ishikai* [A True Story of the Japan Medical Association] (Tokyo, Asahi Shuppan, 1983), 33. Takemi Taro was then the Vice President and resigned with Tamiya.

⁵² See also Akira Sugaya, *Nihon Iryō Seidoshi* [History of Japanese Medical Institution] (Tokyo: Hara Shobō, 1976), 494.

⁵³ Deborah J. Milly, *Poverty, Equality, and Growth: The Politics of Economic Need in Postwar Japan* (Cambridge, MA: Harvard University Asia Center, 1999), 101.

⁵⁴ Kōseishō Gojūnenshi Henshū Inkai, *Kōseishō Gojūnenshi: Kijutsu Hen*, 837; Sugita Yoneyuki, "Universal Health Insurance: The Unfinished Reform of Japan's Healthcare System," in Mark E. Capiro and Yoneyuki Sugita eds., *Democracy in Occupied Japan: The U.S. Occupation and Japanese Politics and Society* (New York: Routledge, 2007), 164.

providers, insurance providers, and representatives of the public.⁵⁵ The new mechanism reconfirmed the government's strong power in health care finance. The government had health insurance costs under control in face of post-war high inflation. The end of the war did not mean that fee-setting power returned to the JMA.

The government continued to press for a radical reform. An urgent issue was that the Government-Managed Health Insurance program had been in deficit, and the deficit rose to six billion yen in 1955.⁵⁶ In response, in the same year, a Seven-Member Committee was created in the MHW to study how the health insurance system should be changed to solve the financial problem.⁵⁷ In October 1955, the Committee submitted a report to the Minister, which included a new fee structure and tighter regulations on doctors who accepted health insurance payments. The report justified stronger government control over doctors on the basis that they had a "public" role.⁵⁸ The government passed the Health Insurance amendment in March 1956 to advance many of the proposals by the Seven-Member Committee.

The Special Committee in the Advisory Council on Social Security submitted a recommendation to the government that Japan should achieve a universal health insurance system by 1961. Dazai Hirokuni, Executive Director of the Advisory Council and the MHW official, declared, "The recommendation included the five-year financial plan by 1961, but I did not personally think universal health insurance would be realized in 1961. I felt that the time flew by very fast but that a strong national mood for social security existed."⁵⁹ His statement suggests that the movement toward universal health insurance was even stronger than bureaucrats themselves might have felt at that time.⁶⁰ In December 1958, the Diet passed a National Health Insurance amendment to realize the proposal by making all municipalities cover their residents.

(2) Too Late for the JMA's Comeback

In the early 1950s, the JMA presidents worked hard to be influential in the policy-making process but they could not do much to counter the government which was intensifying its control over health care. Takahashi Akira and Tamiya Takeo, both well-known Tokyo University professors, tried to make the JMA recognized as a prestigious and powerful group.⁶¹ In 1951, opposing that the government did not allow the fees to increase in proportion to inflation, Taniguchi Yasaburo sought to ask for doctors not to see health insurance patients. Obata Korekiyo also tried to resist the government's efforts to amend the Health Insurance Law from 1955 to 1956. But none of these efforts brought the JMA much success.⁶²

In this circumstance, Takemi Taro was elected the president of the JMA in April 1957.⁶³ Because of his intense performance to the government, particularly the MHW, Takemi was called "Belligerent Taro," *kenka Taro*.⁶⁴ His aggressive, bombastic and provocative personality was well known to the JMA members. He had run for the presidency three times in the past, but never gained enough votes in earlier elections. Hido Shuichi argues that this was because of his strong personality. However, the election in 1957 was different: the same personality helped Takemi get elected.⁶⁵ Many of the JMA members realized that a different and strong leadership would be needed in face of changing political realities.

In addition to his strong personality, the JMA members had a hope that Takemi would use his personal connections in politics to influence the policy-making process. His clinic in Ginza was the perfect place to promote

⁵⁵ Yoshihara and Wada, *Nihon Iryōhoken Seidoshi*, 125.

⁵⁶ Nihon Ishikai Sōritsu Gojūshūnen Kinen Jigyō Suishin Inkai, *Nihon Ishikai Sōritsu Kinenshi: Sengo Gojūnen no Ayumi* [Anniversary of foundation of the Japan Medical Association: Fifty-year progress after World War II] (Tokyo: Nihon Ishikai, 1997), 47.

⁵⁷ Kawakami, *Gendai Nihon Iryōshi*, 285-6.

⁵⁸ Jiro Arioka, *Sengo Iryo no Gojūnen: Iryōhokenseido no Butaiura* [Fifty-Year of Postwar Medicine] (Tokyo: Nihon Iji Shinposha, 1997), 86-87.

⁵⁹ Quoted in *ibid.*, 95.

⁶⁰ *Ibid.*

⁶¹ Taro Takemi ed., *Tamiya Sensei wo Shinobu* [In Memory of Professor Tamiya] (Tokyo: Medicaru Karuchua, 1964), 273.

⁶² Kawakami, *Gendai Nihon Iryōshi*, 510-512.

⁶³ The former president Obata was removed from office in March by an extraordinary House of Delegates.

⁶⁴ For Takemi's background, see Takakazu Yamagishi, "A Short Biography of Takemi Taro, the President of the Japan Medical Association," *Journal of the Nanzan Academic Society Social Sciences* 1 (January 2011): 49-56.

⁶⁵ Hido Shuichi, "Itansha Takemi Taro [A Heretic Takemi Taro]," *Chūōkōron* 79 no. 7 (July 1964), 254.

acquaintance with political figures. His relationship with Makino Nobuaki was especially helpful in this regard.⁶⁶ Makino was the son of Okubo Toshimichi who had played a leading role in the Meiji Restoration.⁶⁷ Takemi's connection with Makino was strengthened by his marriage to Makino's granddaughter. Through this marriage, Takemi also became a relative of Yoshida Shigeru who served as Prime Minister for about seven years after World War II. By serving as Yoshida's personal physician, Takemi became very close to him and began to play an important political role for Yoshida.⁶⁸

In April 1957, Takemi was elected as the JMA's president, receiving 104 representative votes out of 152 votes. Steslicke writes of Takemi's impact on the development of the JMA, "It was not until after the election of Takemi Taro as president in April 1957 that the JMA began to attract widespread attention and condemnation as an *atsuryoku dantai* (pressure group). It is only since Takemi's election and forceful leadership, moreover, that the JMA [became] of key importance in medical care administration and politics."⁶⁹ Mizuno Hajime also notes, "It was Takemi who, for the first time, blundered through discussing and making policies themselves and began to fight [against the government]."⁷⁰

His inaugural speech already demonstrated his strong intention to challenge the government. Takemi said, "When we see the present condition of social insurance, I think that there are many contradictions and other things are needed for reform. The health insurance reform proposal, which we have recently fought against, was out of step with the necessary process of academics and democracy. I recommend a reverse course against police-like authoritarian administration."⁷¹ He was strongly convinced that bureaucrats distorted the health care system in Japan.⁷²

Takemi was elected to recover from the JMA's "lost twenty years." He had to break through the organization's stagnation and he knew that it would be extremely difficult to reverse the path of institutional and political development. Part of his inaugural address affirmed this. He said, "We have a responsibility to offer the technological and social cooperation needed to create a universal health insurance system."⁷³ He also later wrote, looking back at the 1950s, "I was thinking that the road toward universal health care was irresistible."⁷⁴

What Takemi could do to the existing institutions was more limited than commonly believed. Although the JMA members saw Takemi as an influential political figure, the Takemi presidency was born into a system in which he forced many institutional barriers to change. While he used his political connections to get some compromises from the government, such as issues of doctor's right to sell drugs, fees, preferential tax code, he could not obtain fundamental policy change.

Takemi had to assume a much more defensive position vis a vis the Japanese government than did his AMA counterpart in the United States. It was evident by 1950 that Truman's health care reform proposal would not go anywhere. Meanwhile, private health insurance expanded during and after the war. The AMA made a decision to push for the expansion of private health insurance while President Dwight Eisenhower's administration did the same. The federal government had very little direct involvement in health care.⁷⁵ On the other hand, in the 1950s the Japanese government retained much of the power it acquired during the war and the occupation which allowed it to shape health insurance policy and take steps toward universal health insurance. The JMA had "lost twenty years" and it took a long time to recover its influence. The JMA's comeback with Takemi was too late to make any drastic changes to the existing system and could only maximize benefits of the JMA members within the existing system.

⁶⁶ Mizuno, *Daremo Kakanakatta Nihon Ishikai*, 24.

⁶⁷ Hido, "Itansha Takemi Taro," 252.

⁶⁸ Takemi Taro, *Senzen Senchū Sengo* [Before, during, and after WWII] (Tokyo: Kōdansha, 1982), 218. For the details of Takemi's background, see Takakazu Yamagishi, "Short Biography of Takemi Taro, the President of the Japan Medical Association," *Academia Social Sciences* 1 (March 2011), pp. 49-56.

⁶⁹ Steslicke, *Doctors in Politics*, 46.

⁷⁰ Mizuno, *Daremo Kakanakatta Nihon Ishikai*, 64.

⁷¹ "Rinji Daigiin Kai ni okeru Takemi Kaichō no Shūnin Aisatsu," *Nihon Ishikai Zasshi* 37 no. 9 (May 1957), 579.

⁷² For Takemi's thoughts about the government's role, see Takemi, *Jitsuroku Nihon Ishikai*.

⁷³ "Rinji Daigiin Kai ni okeru Takemi Kaichō no Shūnin Aisatsu."

⁷⁴ Takemi, *Jitsuroku Nihon Ishikai*, 59.

⁷⁵ Jacob S. Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (New York: Cambridge University Press 2002).

5. Conclusion

Legislation to achieve universal health insurance in 1958 was major turning point in the history of the Japanese health insurance system. This article demonstrates that the path toward universal health insurance was largely set during the war and solidified after the war. The government's top-down policy to westernize, improve, and rationalize the Japanese medicine discouraged the JMA to participate in the policymaking process. During the war the JMA further handed its power over the government that sought to make war mobilization more efficient. It did not get its power back during the occupation period. This institutional and political development impacted what the JMA could do and could not do in the later period. Takemi appeared to be a strong political actor in the postwar policymaking process, but his presidency was born into a robust institutional setting that he could not drastically change.

This article also reminds us that the institutional and political development in Japan was not linear. There were no determined orders: the Japanese health system was what historical institutionalists would call an inchoate world. Japan could have adopted different policy paths. This article with the comparison with the American case should make us wonder what if the westernization of medicine had been more advanced under the Tokugawa regime, what if the Health Insurance Law had not passed in 1922, and, more importantly, what if WWII had ended differently. It is often said that there is no "if" in history. But without thinking of "ifs," we cannot fully understand how institutions and politics interact to shape policy paths.

To advance this project, it is important to look closely into how institutional and political developments in health care affected interest groups other than the JMA, such as hospital organizations, business groups, and labor unions. By studying them, we can understand the political context of the postwar period more comprehensively.

This paper also has implications for the current health care reform debate. In the face of the recent discussion of *iryō kiki* (health care crisis), the government has not been able to offer fundamental reform. On the other hand, the JMA has not been able to react effectively to the problem, either. Neither has offered more than hodge-podge reforms to the existing health care system and without much engagement in public debate. This paper hopes to help us rethink how the Japanese health insurance system has grown as it has and what the system needs to change.

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